PRINTED: 12/20/2007 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUII			С	
		344003	B. WIN	G		05/0	9/2007
	ROVIDER OR SUPPLIER			2	EET ADDRESS, CITY, STATE, ZIP CODE 01 STEVENS MILL ROAD GOLDSBORO, NC 27530		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
A 038	482.13 PATIENTS' R	IGHTS ct and promote the rights of	A	038			7/1/07
	each patient.  This CONDITION is Based on record revie hospital failed to proteright to be free from restraining technique monitor the patient in hospital's special precuse safe restraining to CFR 482.13(c)(3). The glect for 1 of 1 paticlose observation.  Cross refer: Tag A-0 for Behavior Manager	not met as evidenced by: ew and staff interviews, the ect and promote the patient's neglect and failed to use safe . Specifically, staff failed to accordance with the cautions policy and failed to					
A 058	(patient #1).  482.13(c)(3) FREE FI HARASSMENT  The patient has the ri of abuse or harassme  This STANDARD is I Based on record revie hospital failed to previsampled (patient #1)	ght to be free from all forms ent.  not met as evidenced by: ew and staff interviews, the rent neglect for 1 of 1 patient on close observation. 1 fell from a wheelchair	A	058			7/1/07
LABORATORY	   DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI A. BUIL		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		344003	B. WIN				C 9/2007
	ROVIDER OR SUPPLIER		•	20°	ET ADDRESS, CITY, STATE, ZIP CODE  1 STEVENS MILL ROAD  DLDSBORO, NC 27530	,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHO		LD BE	(X5) COMPLETION DATE
A 058	Findings include:  Medical record review revealed patient #1, a admitted to U2/3 Wes diagnoses of Bipolar Episode Manic, and Abuse. Patient #1 was Further review of the physician's order (ver 9:00am, which indica CO (close observatio)  On 5-9-07 the hospita "Precautions, Special to the policy, "CO is tobservation. Designa shift shall be respons within arms length AT Further review of patirevealed a physician note, dated 4-3-07 at patient #1 had fallen documented "plan: nurse for the CO (close (patient) all the time".  Continued review of prevealed a late entry 4-6-07 at 5:15pm. The entry for 4-3-07: At a (Health Care Technic patient #1) had fallen notifiedNo injuries run on 5-9-07 the hospita in the size of the continued review of prevealed and the entry 4-6-07 at 5:15pm. The entry for 4-3-07: At a (Health Care Technic patient #1) had fallen notifiedNo injuries run on 5-9-07 the hospital continued review of patient #1) had fallen notifiedNo injuries run on 5-9-07 the hospital continued review of patient #1) had fallen notifiedNo injuries run on 5-9-07 the hospital continued review of patient #1) had fallen notifiedNo injuries run on 5-9-07 the hospital continued review of patient #1) had fallen notifiedNo injuries run on 5-9-07 the hospital continued review of patient #1) had fallen notifiedNo injuries run on 5-9-07 the hospital continued review of patient #1)	v conducted on 5-8-07 a 48-year-old male, was st on 3-25-07 with the Disorder, Most Recent Alcohol and Cannabis as discharged on 4-12-07.  medical record revealed a rbal order), dated 3-26-07 at ted patient #1 was placed on n) 1:1 precautions.  al's policy entitled " was reviewed. According he most restrictive level of ated staff members on each ible for keeping the patient - ALL TIMES".  ent #1's medical record assistant (PA) progress 4:00pm. The note indicated from his wheelchair. The PA Case discussed with staff se observation) to be with pt  patient #1's medical record nursing progress note, dated he nurse documented "Late pproximately 3:30pm, HCT ian) reported that (name of out of his wheelchair. PA	A	058			

Facility ID: 956127

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	ROVIDER OR SUPPLIER		20	EET ADDRESS, CITY, STATE, ZIP CODE 11 STEVENS MILL ROAD OLDSBORO, NC 27530			
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A 058	incident under investimembers reported a (Staff #1) left patient notify appropriate state observation 1:1 and funattended. According the incident occurred on 5-9-07 the U2/3 V4-3-07 was reviewed document, staff #1 wobservation) for paties (7am-3:30pm).  Further review of the documentation of an staff #1. The interviex conducted by a patient manager. According of the shift (3:30pm) the needed to leave a interview with the admotified another Healthe was leaving and spatient #1. Further revealed "I (staff #1) (staff #2) was going to 5-9-07 an interview with patient #1 on 1st reported it was during very important place asked a 2nd shift staff recall this staff's nam "gave him the board" CO). Staff #1 reported	ding to the report, the gation was as follows: Staff Health Care Technician #1 "unattended" and did not ff. Patient #1 was on close ell from the wheelchair while ing to the investigation report, on 4-3-07.  West Assignment Sheet for According to the as assigned CO (close int #1 for 1st shift investigation report revealed interview conducted with with with staff #1 was int advocate and nurse to the interview, at the end on 4-3-07, staff #1 reported ind go pay a light bill. In the vocate, staff #1 reported he th Care Technician (staff #2) taff #2 agreed to watch eview of the interview was pretty secure that he	A 058				

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		344003	B. WIN				0
NAME OF PF	ROVIDER OR SUPPLIER	344003		STE	REET ADDRESS, CITY, STATE, ZIP CODE	05/09	9/2007
CHERRY	HOSPITAL			2	201 STEVENS MILL ROAD GOLDSBORO, NC 27530		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDERICIENCY)	D BE	(X5) COMPLETION DATE
A 058	he worked on another investigation. Staff # back on U2/3 West. A currently could not be patient #1 (patient #1 could be assigned CO.  Further review of the report revealed docur conducted with staff # Technician). The interpatient advocate and interview revealed staff and heard patient #1 Staff #2 reported staff CO 1:1 with patient # brought me the clipboleave". Documentation wife staff #1 intending the cover his CO 1:1 with patient # brought me the staff #1 intending the cover his CO 1:1 with patient # brought me the clipboleave". To me he (staff #1) with patient # brought me the clipboleave with the staff #2 reported with assignment had "Actually we didn't gethere wasn't no nursed didn't actually get repidin't tell us anything saw us they left. We assignment".  On 5-9-07 an interviee #2. Staff #2 reported signs table and heard revealed it was shift to 2nd shift) had been a time. Staff #2 reported who had been working the country is the country in the country in the country is the country in the country is the country in the country is the country in the country in the country in the country is the country in the	days later. Staff #1 reported r unit (U2/3 East) during the 1 reported he was currently According to staff #1, he assigned CO 1:1 with had been re-admitted), but 0 1:1 with other patients.  advocate's investigation mentation of an interview #2 (2nd shift Health Care erview was conducted by a nurse supervisor. The aff #2 was doing vital signs fall out of the wheelchair.	A	058			

1 '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP  A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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A 058	had to go and dropper reported they (2nd shreport so they just star Further review of the documentation of an staff #3 (2nd shiff Heinterview with staff #3 advocate. The interview assisted patient #1 bis Staff #3 stated he did assigned to patient # through the dayroom  On 5-9-07 an interview #3. Staff #3 reported the assignade out yet and he started a head count According to staff #3 ran on he was OK. According crawling and staff #3 wheelchair. Staff #3 not know who was Cow #3 reported he now with staff (staff #1) that has #1.  On 5-9-07 an interview #4, a Registered Nurworking from 7am-7p (4-3-07). Staff #4 registered nurse went to Health Care Technici According to staff #4,	and the clipboard off". Staff #2 sift) had not been given arted working.  investigation report revealed interview conducted with alth Care Technician). The B was conducted by a patient iew revealed staff #3 ack to the chair after his fall. I not know who was 1. "I was just coming making my rounds".  w was conducted with staff he came in that day (for 2nd e "a little unorganized". Staff nment sheet had not been just "went to work". Staff #3 on all the patients. staff #2 said patient #1 had wer to patient #1 and asked if ng to staff #3, patient #1 was helped him back to his revealed at that time he did O 1:1 with patient #1. Staff was aware of the 1st shift d been assigned to patient	A 058				

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	ROVIDER OR SUPPLIER		-	2	REET ADDRESS, CITY, STATE, ZIP CODE 01 STEVENS MILL ROAD GOLDSBORO, NC 27530		
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A 058	a section which outlin investigation regardin indicated the investig secondary to reports (who was on CO 1:1) without proper relief. and fell while trying to The document stated evidence" that staff # being relieved and vic regarding close observindicated staff #2 and temporary supervision issue could be address the report, there was assignment sheet not shift arrived and Heal beginning the shift wistaff.  Further review of the "Investigation Team Foutlined action to be finvestigation regarding."	cian assistant).  investigation report revealed ed the conclusions of the g patient #1. The document ation was conducted that staff #1 left patient #1 at the end of the shift Patient #1 was unattended get out of his wheelchair. There was "conclusive 1 left his assignment before plated the hospital's policy reation. The report further #3 did not "provide n" to patient #1 until the ased/resolved. According to also "concerns" about the being complete when 2nd th Care Technicians thout direction from licensed report revealed Recommendations", which taken as a result of the g the incident with patient erview was conducted with	A	058			
	discussed the proces According to the DON formal disciplinary ac infraction (including w expectations (what sh time frame for improv the employee fails to According to the DON reviewed by the Hum	s for disciplinary action.  I, staff #1 would receive tion to include: the specific which policies were violated), hould be done to improve), ement, and what will occur if					

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NAME OF PR	OVIDER OR SUPPLIER			2	REET ADDRESS, CITY, STATE, ZIP CODE 201 STEVENS MILL ROAD GOLDSBORO, NC 27530		572001
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF COI PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)		LD BE	(X5) COMPLETION DATE
A 071	action will be presenthe date of the surve had not received formincident that occurred. Interview with staff # been asked that morpolicy regarding clos. Further interview with and #3 were to receit According to the DO were not considered. As of the date of the supervisory conferent not yet occurred. The manager was in the completing the action the investigation regates. 13(e)(3)(v) SAFF TECHNIQUES  The use of a restraint safe and appropriate. This STANDARD is Based on record revide documentation, and procedures, the hosp appropriate restraint sampled (patient #1). Findings include:	eported then the disciplinary ted to the employee. As of y (May 8-9, 2007), staff #1 mal disciplinary action for the d on 4-3-07.  1 on 5-9-07 revealed he had ning (5-9-07) to review a e observation.  In the DON revealed staff #2 we supervisory conferences. N, supervisory conferences formal disciplinary action. survey (May 8-9, 2007) aces with staff #2 and #3 had e DON indicated the nurse process of working on the sto be taken as a result of arding patient #1.  E RESTRAINING  It must be in accordance with restraining techniques.  In the DON indicated the nurse process of working on the store taken as a result of arding patient #1.  E RESTRAINING		058			7/1/07

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A 071	Episode Manic and A Patient #1 was dischalled Further review of med documents completed patient #1. "Healthca at 6:30pm indicated repatient #1. "Healthca at 6:30pm indicated repatient #1. The document Assessment" noted "during the admission "Physical Assessmer 8:45 am, patient #1 health pain screen was negled documentation for painjuries or reports of preserview of "Restrict Note", patient #1 was to the use of restrictive was "given Seroquel lability". The note furt PO (by mouth) at 1:3 lability." According to unable to be redirected staff in the face, but sinstead. According to the restrictive interves 3-26-07 at 6 am, the NCI hold patient hit heame assessment durintervention monitorir "complaining of right soreness. Right kneet laceration on head-sured 3-26-07 at 7:26	Disorder- Most Recent and Cannabis Abuse. arged on 4-12-07.  dical record revealed dupon the admission of re Checklist" dated 3-25-07 no injuries to his legs or entitled "Learning ambulatory with normal gait" assessment. On the att form dated 3-25-07 at ad no swollen joints and the ative. Review of admission tient #1 revealed no current pain or discomfort.  Active Intervention Progress are restrained on 3-26-07. Prior receintervention, patient #1 50 mg @ 12:10 am for mood the note, patient #1 was and and he attempted to hit attruck staff's shoulder the nursing assessment on an intion note completed on nurse documented "during lead on door jam". On the ring the 30-minute post and section, the nurse noted knee discomfort and head with redness. 2 1/2 inchutures".	A 071				
		ent complained of laceration					

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A 071	s assistant also noted of head with mild bled at 8:15 am by the phydocumented the sutu head of patient #1. To documented no prior pain and discomfort.  Physician orders wer 5-8-07. Entry on 3-26 order for Tylenol 650 prn (as needed) for pknee; and Keflex 500 day) for laceration processes and keflex 500 day. West on the nigwas interviewed, and was very confused. Fan account of how he his head or how his rand sore. The alleged account, which involving patient #1. Per report was not restrained or down on the floor after initiated. Per alleged #1 was held for only Health Care Technicis shift provided a differ #1 became injured. To patient #1 was restra alleged perpetrator. Experpetrator and patient patient #1 was restra alleged perpetrator. Experpetrator and patient patient #1 was restra alleged perpetrator. Experpetrator and patient #1 was restra alleged perpetrator.	tercation " . The physician ' d " 4-5 cm laceration on top eding " . Note dated 3-26-07 //sician 's assistant ring of the laceration to the ne progress notes injuries or complaints of  e reviewed for patient #1 on 1-07 at 7:20 am revealed an mg p.o q. (every) 6 hours ain; Ace bandage for right mg 1 pill po qid (4 times per ophylaxis " .  restigation completed by the ealed the investigation began	A 071				

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A 071	on 5-8-07. The direct perpetrator has been investigation was correturned to work. The actions taken against providing misleading against the nurse on determine the cause Further interview with nurse and the charge supervisory conferen supervisory conferen formal disciplinary active (May 8-9, 200 with the charge HCT not yet occurred. The manager was in the prompleting the action the investigation regard An interview was conton 5-9-07. The HCT proformation documen investigation. Per interpetrator restrained and the pair fell back hit his head on the was account identical transport investigation. The allest the placed patient #1 minute and patient #1 minute and patient #2 hold was over. He preservices or several preserves the preserve investigation and patient #1 minute and patient #2 hold was over. He preserves account identical transport in the preserves in the preserves account identical transport investigation. The allest placed patient #1 minute and patient #2 hold was over. He preserves account identical transport in the preserves in the preserves investigation account identical transport investigation. The allest placed patient #1 minute and patient #2 hold was over. He preserves account identical transport in the preserves investigation account identical transport investigation.	and Services was interviewed or reported the alleged on leave with pay while the appleted. To date, he had not a director also outlined the athe charge HCT for information and the actions duty for not following up to of the injury for patient #1. In the DON revealed both the eHCT were to receive ces. According to the DON, ces were not considered tion. As of the date of the 7) supervisory conferences and the nurse on duty had the DON indicated the nurse or ocess of working on the stop be taken as a result of the arding patient #1.  Inducted with the charge HCT provided the same ted in the internal terview, the alleged of patient #1 with a bear hug wards to the floor. Patient #1	A 071				

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A 071	came to the assistant him up. The source of after patient #1 was to the nurse could proviperpetrator maintained he did nothing wrong initiated properly.  The facility maintains the use of restrictive Care shall be taken to mental discomfort in interventions. In area interventions are use to ensure humane, so 482.23(b)(3) RN SUF CARE  A registered nurse more the nursing care for exampled (patient #1) Specifically, patient # while left unattended.  Findings include:  Medical record review revealed patient #1, and admitted to U2/3 West diagnoses of Bipolar Episode Manic, and after the source of the patient #1, and pat	on the floor. The perpetrator ce of patient #1 and helped of the blood was discovered being walked to a chair so de first aid. The alleged ed during the interview that and his restraint was a policy and procedures on interventions. Per policy, "o minimize physical and the use of restrictive s where restrictive d, provisions shall be made ecure, and safe conditions". PERVISION OF NURSING was supervise and evaluate each patient.		204			7/1/07

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
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A 204	physician's order (ver. 9:00am, which indicated CO (close observation). On 5-9-07 the hospital "Precautions, Special to the policy, "CO is to observation. Designation of the policy of patroverse of patroverse of patroverse of patroverse of patroverse of the CO (cloor (patient) all the time."  Continued review of patroverse of the CO (cloor (patient) all the time."  Continued review of prevealed a late entry 4-6-07 at 5:15pm. The other of the CO (cloor of the patient #1) had falled notifiedNo injuries in the patient #1) had falled notifiedNo injuries in the patient was reviewed. According to the patient investing appropriate state observation 1:1 and the properties of the patient	medical record revealed a rbal order), dated 3-26-07 at ted patient #1 was placed on n) 1:1 precautions.  al's policy entitled   was reviewed. According he most restrictive level of ated staff members on each lible for keeping the patient assistant (PA) progress 4:00pm. The note indicated from his wheelchair. The PA Case discussed with staff se observation) to be with pt   catent #1's medical record nursing progress note, dated he nurse documented "Late approximately 3:30pm, HCT can) reported that (name of out of his wheelchair. PA noted".  al's investigation report leted by a patient advocate, rding to the report, the gation was as follows: Staff Health Care Technician #1 "unattended" and did not ff. Patient #1 was on close fell from the wheelchair while and to the investigation report,	A	204			

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NAME OF PROVIDER OR SUPPLIER  CHERRY HOSPITAL			20	EET ADDRESS, CITY, STATE, ZIP CODE 01 STEVENS MILL ROAD GOLDSBORO, NC 27530		0/2001
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
A 204	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 14 assisted patient #1 back to the chair after his fall. Staff #3 stated he did not know who was assigned to patient #1. "I was just coming through the dayroom making my rounds".  On 5-9-07 an interview was conducted with staff #3. Staff #3 reported he came in that day (for 2nd shift) and things were "a little unorganized". Staff #3 reported the assignment sheet had not been made out yet and he just "went to work". Staff #3 started a head count on all the patients. According to staff #3, staff #2 said patient #1 had fallen. Staff #3 ran over to patient #1 and asked if he was OK. According to staff #3, patient #1 was crawling and staff #3 revealed at that time he did not know who was CO 1:1 with patient #1. Staff #3 reported he now was aware of the 1st shift staff (staff #1) that had been assigned to patient #1.  On 5-9-07 an interview was conducted with staff #4, a Registered Nurse. Staff #4 reported working from 7am-7pm on the day patient #1 fell (4-3-07). Staff #4 reported hearing someone call for a nurse. Interview revealed staff #4 and another nurse went to see what happened and a Health Care Technician said patient #1 had fallen. According to staff #4, patient #1 had no injuries and patient #1 said he was not hurt. Staff #4 notified the PA (physician assistant).  Further review of the investigation report revealed a section which outlined the conclusions of the investigation regarding patient #1. The document indicated the investigation was conducted secondary to reports that staff #1 left patient #1 (who was on CO 1:1) at the end of the shift		A 204			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  344003		` IDENTIFICATION NUMBER:		ULTIPLE LDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B. WING			C <b>05/09/2007</b>		
NAME OF PROVIDER OR SUPPLIER  CHERRY HOSPITAL				201	ET ADDRESS, CITY, STATE, ZIP CODE STEVENS MILL ROAD LDSBORO, NC 27530		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD E TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			(X5) COMPLETION DATE
A 204	and fell while trying to The document stated evidence" that staff # being relieved and viregarding close obse indicated staff #2 and temporary supervisio issue could be addre the report, there was assignment sheet no shift arrived and Hea beginning the shift wistaff.  Further review of the "Investigation Team I outlined action to be investigation regardir #1. On 5-9-07 an intended the Dorector of Nursing discussed the process According to the DON formal disciplinary according to the DON reviewed by the Humand the DON and assoff on it. The DON reaction will be present the date of the survey had not received form incident that occurred	Summary STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 15 and fell while trying to get out of his wheelchair. The document stated there was "conclusive evidence" that staff #1 left his assignment before being relieved and violated the hospital's policy regarding close observation. The report further indicated staff #2 and #3 did not "provide temporary supervision" to patient #1 until the issue could be addressed/resolved. According to the report, there was also "concerns" about the assignment sheet not being complete when 2nd shift arrived and Health Care Technicians beginning the shift without direction from licensed staff.  Further review of the report revealed "Investigation Team Recommendations", which outlined action to be taken as a result of the investigation regarding the incident with patient #1. On 5-9-07 an interview was conducted with the Director of Nursing (DON). The DON discussed the process for disciplinary action. According to the DON, staff #1 would receive formal disciplinary action to include: the specific infraction (including which policies were violated), expectations (what should be done to improve), time frame for improvement, and what will occur if the employee fails to make improvements. According to the DON, the document must be reviewed by the Human Resources Specialist, and the DON and assistant DON must also sign off on it. The DON reported then the disciplinary action will be presented to the employee. As of the date of the survey (May 8-9, 2007), staff #1 had not received formal disciplinary action for the incident that occurred on 4-3-07.  Interview with staff #1 on 5-9-07 revealed he had		204			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
	344003		B. WING			С	
NAME OF PF	ROVIDER OR SUPPLIER	344003		STREET ADDRESS, CITY,	, STATE, ZIP CODE	05/09	9/2007
CHERRY HOSPITAL				201 STEVENS MILL R GOLDSBORO, NC	ROAD		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)			(X5) COMPLETION DATE
A 204	Continued From page	e 16	Α:	204			
	and #3 were to receive According to the DON were not considered. As of the date of the supervisory conferent not yet occurred. The manager was in the part of the supervisory was in the part of the p	the DON revealed staff #2 we supervisory conferences. N, supervisory conferences formal disciplinary action. survey (May 8-9, 2007) ces with staff #2 and #3 had a DON indicated the nurse process of working on as to be taken as a result of arding patient #1.					